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## Original Communications.

### NOTES FROM AN OBSTETRICAL CASE-BOOK.

By J. G. BLAKE, M.D., Boston. Read before the Boston Society for Medical Observation, Dec. 3, 1870.

THE patient, Mrs. M., a strong, healthy woman, of Irish birth, has been delivered of four still-born children—three with forceps, and the fourth by craniotomy. Having been her medical attendant for some years, I have been with her three times at her labors—once forceps, once craniotomy, and the case of induced labor.

My first experience, from the great difficulty in effecting delivery by forceps after waiting thirty-six hours, satisfied me that it would be impossible for a child of the average size, at the full term, to pass alive. This was not on account of any special deformity of the pelvis, but from a general narrowing of the natural diameters. With the assistance of Dr. B., and after two hours' hard work, a still-born child was delivered—with long forceps.

The mother made a good recovery, and after the lapse of fifteen months, I was summoned to attend her again. On this occasion, the labor progressed slowly for a time, but after several hours it became evident that the head could not enter the brim of the pelvis without assistance. Long forceps were applied, and all the force deemed justifiable used, but without effecting the slightest progress. Finding assistance needful, I sent for the gentleman who so kindly lent his aid on a former occasion, but he was unable on account of illness to come. Dr. C. came instead, and after etherizing the patient, again applied the long forceps, but without any result.

Before resorting to craniotomy, podalic version was tried, but without enabling us to deliver the head. After pulsation in the cord ceased, nothing remained but perforation, which was done under some disadvantages. If unfortunate enough to have another case requiring craniotomy, I should hesitate about attempting to effect delivery

by podalic version after a fair trial with forceps. By it, the head becomes immovably wedged into the pelvis, while the vagina is completely filled by the child's neck. Besides this, the head must be pierced at the most difficult part—the occiput.

Our instrument bag not containing a cephalotribe, and the woman's condition not admitting of postponing delivery sufficiently long to obtain one, Dr. C. introduced Smellie's scissors, and pierced the head through the occipital bone; then separating the blades, broke up the substance of the brain. Efforts to evacuate the brain were now made, and attempts at extraction by means of the forceps and traction of the legs, but without success. The blunt hook was also repeatedly used, but every point to which it was applied yielded, and after four hours continued effort, the patient remained undelivered. She seemed sinking fast; pulse weak and fluttering, respiration slow and gasping, and with every indication of approaching dissolution.

Dr. C. and myself were by this time very much exhausted, and summoned Dr. K. to our assistance. He came, and after an hour and a half finally succeeded in delivering the child's head.

The woman made a good but slow recovery. During the after treatment, I told her that if she became again pregnant, it would be absolutely necessary—in order to save her own life and afford her a chance of having a living child—to induce labor at the seventh month. To this she agreed.

Soon after, she became pregnant again. With the hope of somewhat diminishing the size of the child, I gave her, after the third month, large doses of iodide of potassium, and continued this treatment up to the seventh. When this period was reached, premature labor was induced in the following manner:—

A sponge tent was introduced into the os, and allowed to remain all night. It was withdrawn in the morning, and the parts not being sufficiently dilated, a larger one was inserted, and allowed to remain six hours. After this was removed, the os was found fully opened. A dose of ergot was

given, which had the effect of producing several strong pains, and the membranes having been ruptured, in a short time the head could be felt presenting at the brim.

The pains died away, and after a lapse of six hours, ergot was again given in a full dose. This was soon followed by strong uterine contractions, but without advancing the head. So long a time elapsed without making any progress, that I feared being again obliged to resort to craniotomy, but resolved first to try the forceps.

I did so. After considerable force, and assisted by the expulsive efforts of the uterus, I succeeded in extracting a living child, much to my own satisfaction and the delight of the mother.

Everything has since gone on in an entirely satisfactory manner. Milk appeared in the breasts on the fourth day, and continued to be secreted in abundance. The child, which was well formed, but small at birth, is now growing rapidly, and promises to be as strong and vigorous as if it had reached the full term.

#### ASTHMA BRONCHIALE. BRONCHIAL SPASM OF CHILDREN.

By Dr. L. M. POLITZER. Translated from the *Jahrbuch für Kinderheilkunde und Physische Erziehung*. Neue Folge, III. Jahrgang, 4 Heft, by C. P. PUTNAM, M.D., Boston.

DURING the last few years a disease of the respiratory organs has come several times under my observation and treatment, which, by reason of its unusual form, its peculiar nature and course, has shown itself to be so different from the diseases of childhood hitherto observed and described, that I think it worth while to make the following communication, in order to complete the observations of others:

To the appearances of the disease to be described I shall give the name of Asthma Bronchiale, or Bronchial Spasm.

Although perfectly well known as a disease of adults, yet not sufficiently well understood, it is, as far as I know, nowhere mentioned as occurring in the case of children, at least in the characteristic form in which I have met with it, or at any rate nowhere recognized as a special form of disease.

I am inclined to consider this asthma bronchiale as an idiopathic, essential disease of the bronchial muscles and of the nerves which regulate their contractions, although, according to the observations hitherto made, it always appears as a sequence of bronchial catarrh, as will be seen

hereafter. Whether and to what extent this opinion is justifiable, will be learned from the description of the disease in question, drawn from the observations within my reach.

I will first describe the cases, of which only the more marked and characteristic will be given in detail; others less important will be but hastily sketched.

CASE I.—Peter G., 16 months old, fed from the breast of a nurse, suffering from chronic eczema of head and face, anæmic, rachitic, frail, of very strong but obese parents, had had up to this time no acute disease. This sickness made its appearance in midsummer, in a healthy mountain region, free from dust, in the neighborhood of Vienna. In the beginning there were to be found only symptoms of ordinary bronchitis of the greater and smaller tubes—fever, high temperature, accelerated pulse, hurried respiration—on auscultation coarse and fine vesicular râles, percussion normal, movement of the diaphragm indicating nothing unusual, but such as is found in every dyspnoea caused by bronchitis. The respiration continued in the same state for some days, but gradually returned to its normal condition, for, as the fever diminished under quinine, the bronchitis and the symptoms belonging to it disappeared also.

After some days of undisturbed convalescence, I was called in urgent haste and found the child again attacked with excessive dyspnoea, so that, at the first moment, I thought there was a return of the bronchitis. On more careful examination, however, I was struck with the contradiction between the severe dyspnoea, and a normal temperature. Percussion was as before normal, but auscultation showed complete absence of all râles except a high fine whistling, heard during the whole respiratory act. Beside this was a marked state of sopor, also difficult to reconcile with the absence of fever. The peculiarity of the dyspnoea consisted in the fact that with respiration of 50 or more there was a prolonged, whooping, whistling inspiration and expiration audible at a distance, and excessive drawing-in of the epigastrium during inspiration, also expression of great distress in moments of consciousness, with lividity and coolness of face. What was also striking was the very infrequent cough, which had a dry, whistling sound, much resembling laryngeal cough. I confess that in the beginning I was not able to reconcile these contradictions, as I could not place this, to me, unknown disease, in any recognized class. But when I returned in

the evening and found the child free from dyspnoea, in good spirits, and also, just as during the attack, free from all fever, while on auscultation no whistling and only rough respiration with insignificant râles were to be heard in the lungs, I was forced to consider as plausible, the idea of a spasmodic form of dyspnoea.

The surprises and problems offered by the case were not yet exhausted, for, on visiting the child on the afternoon of the next day, I found him, after a night of quiet sleep and a forenoon free from dyspnoea, in a state almost exactly like that of the preceding day—the same prolonged, whistling, whooping and quickened respiration, audible at a distance—the same whistling and hissing râles on auscultation—the diaphragm acting with excessive drawing-in of the epigastrium and false ribs—again the livid, cool face, continual state of sopor without elevation of temperature, but, as I had already noticed in the first attack, a very small quick pulse of 168; finally, almost an absence of cough. Since, in spite of its resemblance to this case, croup was of necessity excluded as well as pneumonia, bronchitis and œdema of lungs, I could not but refer the dyspnoea to a spasmodic contraction of the bronchi, and make as the diagnosis—asthma bronchiale.

The resemblance to, nay the identity with asthma bronchiale as it occurs frequently in cases of emphysema was not to be questioned; and now for the first time I remembered that I had seen such a case but once, and that 3 years before, in a girl 4 years old, when, having been sent for in the night, I found the same severe dyspnoea, but also, in addition to the universal whistling, a fine râle, so that from the sudden appearance of the symptoms, there was forced upon my mind, beside the idea of capillary bronchitis, also that of acute œdema of the lungs; but to my great surprise I found the child entirely well the next morning. The recollection of this case (to which I shall return hereafter), confirmed me in the above diagnosis, viz.: Asthma bronchiale, and the further course of the disease not only proved the correctness of my diagnosis, but convinced me of the propriety of placing it in the nosology of children's diseases.

I now turn to the description of its further progress, which, although interesting in its details, can only be presented with its most prominent features. For fully four weeks the child suffered from attacks like the above, with varied duration and longer and shorter intervals of freedom. In the beginning it was not typical, but returned at in-

tervals of from one to three days, lasting six, eight, or twelve hours, often occurring in the night, and always following perfectly free intervals of one, two, or three days; but finally, in the last ten days, a strictly typical character developed itself, and the attacks of asthma came on with perfect regularity at about 10 A.M.—in the last few days, just before improvement began, at 1 P.M. The duration of the attacks, too, was strictly typical, as they ceased at 9 or 10 P.M., and the child passed the night quietly. During these four weeks the bronchial catarrh never completely disappeared. There was some dry cough, even when there was no asthma, and auscultation always showed quiet respiration, sometimes insignificant whistling, and few or no râles. On the whole, the catarrh was so slight that it was impossible to think of a relation of cause and effect between the two diseases. As a final characteristic another important symptom should be mentioned, viz.: after about three or four attacks the distention of the lung went far beyond its normal limits during the spasm; in other words, the heaping up of air in the pulmonary vesicles from the contraction of the bronchi resulted in vesicular emphysema, which, however, disappeared 24 hours afterwards, and only later became persistent after repeated spasms, with ever increasing severity, and lasted two months after the asthma had entirely ceased, especially at the lower posterior part of the left lung. It, however, gradually disappeared. Thus we see that the emphysema, which appeared secondarily, lasted some months after the asthma had disappeared. It should also be remarked that during the five weeks of the child's sickness, and synchronously with the increase of frequency and intensity of the attacks, especially in the last fourteen days, when each one came on with excessive asphyxia, the child lost much flesh, but afterwards gradually regained it. During the two years in which I had opportunity to observe him, he remained entirely free from asthma, though now and then suffering from catarrh.

The treatment was, in the beginning, regulated with reference to the bronchitis. Later, as the character of the asthma pronounced itself more and more clearly, I turned to those remedies which experience has shown to be more or less useful in bronchial spasm of adults and laryngeal spasm of children—val. of zinc, cannabis indica, belladonna, ipecac., but especially musk and quinine. Of these, the last two appeared to be the only ones which had any

effect in this case. Emetics were of no use. When the attacks had acquired a typical character, I often succeeded in delaying or entirely arresting them by means of quinine given just before the attack was expected to begin. Musk, given during the spasms, seemed to mitigate their severity. In severe attacks, accompanied by sopor or asphyxia amounting to suffocation, ammonia in the form of liquor ammoniac anisatus appeared to be useful in bringing about more forcible respiratory movements through irritation of the medulla oblongata. All these remedies may have had the effect of mitigating or shortening, or, like quinine, of delaying the spasms, but they were not sufficient to arrest them altogether. This was effected only when I applied a remedy which has often shown itself to be useful in laryngeal spasm, and which I have also used with success in other affections of the nerves, motor and sensitive, viz., chloride of bromium. In one of the next numbers of this Year-book, I shall publish a communication on this remedy, which I have used for eighteen years in manifold nervous diseases. Here I will only say that in this case I used the drug in the following formula, in which children generally take it willingly, and in which it is least likely to be decomposed:—

R. Aque feniculi,

Syrupi capillorum\*, aa ʒi;

Brom. chlorid., gtt. iij.

S. One teaspoonful every two hours. A colored, glass-stoppered vial should be used.

After four days' administration of the above, the attacks ceased. It was given two days longer, since which time there had been no return, and, as I have stated above, the child remained entirely free from asthma during the two years that I was able to observe him.

CASE II.—Oscar W., 15 months old, though of pretty good size for his age, exhibited a less favorable development of fat and muscle. He had been subject to bronchial catarrh from his birth, and also suffered from coryza chronica (may well add, catarrhalis). The latter was commonly accompanied with profuse secretion of mucus, which interfered with the permeability of the nose and forced the child to breathe through the open mouth, with a snoring respiration, but without dyspnoea, and finally led by its long duration to an arrest in the development of the thorax. The child suffered also, as in Case I., from chronic, general, but not very severe eczema. He

\* The syrup of orange flower is often substituted for the "syrup capillorum."

had shown no symptoms of dyspnoea which would have reminded one of asthma, even when he had had an acute catarrh in addition to the chronic one. In December, 1869, when the child was 15 months old, the asthma came on in full force, a few hours after an attack of catarrh and moderate fever. The asthma differed, however, from that in the former case, in that, together with a well-marked laryngeal cough, such as occurs in cases of severe laryngeal catarrh, and laryngeal croup, there was also that characteristic jerking inspiration, in consequence of the violent action of the diaphragm, and following, without any interval, the prolonged whistling expiration, and this became as prominent in the first few hours of the attack as it is in croup of the severest type. Another symptom developed itself that is met with in croup, viz.: coma, but, contrary to what happens in croup, it occurred a few hours after the access of the disease. It was an evidence of poisoning by carbonic acid and its effect on the medulla oblongata. I confess that, at the first glance, I took its symptoms as a whole, to mean croup. But I was obliged after a time to give up this idea, for not only was there no hoarseness, but, as is worthy of notice, the dyspnoea, which came on in the very beginning of the disease, continued uniform throughout (i. e., not aggravated at intervals to suffocation, as in laryngeal croup, by intermittent spasmodic contraction of the larynx). In addition to this, the carbonic acid poisoning came on too early for croup, and finally the fine whistling, heard on auscultation, all over the thorax, the absence of fever, &c., taken in connection with the above symptoms, justified me, as I think, in excluding croup, and adopting bronchial spasm as the cause of the dyspnoea.

With the diagnosis asthma, I gave a very favorable prognosis to the anxious parents, who, to my surprise, told me that asthma was hereditary in their family. The other symptoms were like those of the asthma in Case I., i. e., on auscultation the fine whistling sound, heard uniformly over the whole chest—the whistling respiration audible at some distance to the unassisted ear—the pale, cool face, the excessive straining of the diaphragm and other muscles of respiration.

Twenty hours afterwards, every trace of the asthma had disappeared. The child was perfectly cheerful, respiration quiet, with normal pauses, and now the cough became more severe, though during the asthma it had been hardly noticeable.

After ten weeks of perfect health, the child had a second, and, two months later, a third attack, which, like the first, followed twenty-four hours after an acute nasal and moderate bronchial catarrh. These attacks had exactly the same distinguishing marks as the first, and disappeared as that did in twenty or twenty-four hours.

With regard to treatment, I will say that, profiting from my experience in Case I., I resorted immediately to chloride of bromium, but on account of the urgency of the dyspnoea, used musk in addition, and therefore must still leave it a doubtful matter, which of the two, or, to be strictly critical, whether either of the two had any effect, or whether the attack came to its natural end after twenty hours duration. I must also not fail to mention that the child vomited violently in the first and most severe attack, and also in the second, after it had already lasted an hour, and thereby threw off a large quantity of mucus, but without mitigating the bronchial spasm. This is a proof not only of the uselessness of emetics in spasm of the bronchi, but also of the nervous spasmodic nature of the asthma in question, for the dyspnoea would of necessity have been diminished, at least temporarily, by an abundant vomiting of mucus, if it had been caused, as in capillary bronchitis, by swelling of the bronchi and obstruction by the secretion.

I will state briefly three other cases of bronchial spasm, which I observed, from which some new characteristics will be learned for completing the picture of the disease.

The first, which I mentioned cursorily in Case I., is that of a delicate anemic girl, four years old, who had passed a greater part of the year at a distance from Vienna. I was repeatedly assured that she had had in the last two years, during the summer and fall months, sudden attacks of dyspnoea without fever, which generally came on at night, and disappeared entirely before morning.

At length the child had such an attack while in Vienna, in the night, and I found her in a state of asthma, though at that time, as this was the first case which I had seen, I did not make this diagnosis, especially because fine râles in certain parts of the lungs and fever were found together with severe dyspnoea, and I supposed it to be an alarming case of capillary bronchitis.

A two-fold surprise awaited me the next morning, when I found the child entirely free from dyspnoea, very cheerful, and with-

out fever, and the day after, she was running about without restraint.

I had to confess to myself that my diagnosis, capillary bronchitis, had not been correct, and had to credit the assurances, spoken of above, with regard to other attacks.

A fourth case occurred in the practice of a learned colleague, which I saw only hastily. It was a child ten months old, which was attacked with such violence that the physician believed it had a very intense capillary bronchitis, and must die in the course of the night, but having been called in consultation I was able, from my experience in the above cases, to give the diagnosis asthma, and a more favorable prognosis. To his great surprise, the physician found the child next day almost perfectly well.

The fifth and last case which has occurred as an indubitable bronchial spasm, was that of a pale, nervous boy 6 years of age. The peculiarities of the case consisted in the fact that a severe catarrh, with fever, came on, and in twenty-four hours developed into asthma, which, contrary to my experience in the other cases, lasted nearly three days, with slight oscillations. In this case also, chloride of bromium was beneficial.

I will now bring up for consideration a few questions on the preceding cases, and, in answering them, endeavor to draw some conclusions with regard to the etiology and pathology, as well as the diagnosis and treatment of the disease.

First of all we must ask, does this disease correspond to our notion of asthma or bronchial spasm of adults; and has asthma bronchiale a right to a place among the diseases of children?

This question is to be answered unconditionally in the affirmative.

The combination of symptoms found in the five observed cases corresponds exactly to asthma of adults arising from spasm of the bronchi. It has all the marks of the so-called asthma nervosum, so described by the best observers, Romberg and others. 1st. The attack of severe dyspnoea either comes on suddenly, or at least rapidly, while the patient is in perfect health, or, if preceded by bronchitis, seldom requires as much as two or three days for full development. In the same way it ceases instantaneously, or in a few hours. 2d. The catarrh which precedes or coexists with it does not disprove the fact that it has a nervous origin (a characteristic of asthma of adults), for, on the one hand, the excessive dyspnoea is entirely out of proportion to the

catarrh, which is often inconsiderable; and, on the other hand, the asthma may cease entirely and the catarrh continue with increased severity. 3d. Just as, in order to prove the nervous nature of asthma of adults, and its origin in spasm of the bronchial muscles, it is necessary to prove the absence of all primary anatomical disturbances, within or without the lungs or bronchi, which could cause the dyspnoea, so in these cases of bronchial asthma in children observed by me, absolutely every other known cause of dyspnoea is excluded. 4th. That which vindicates even more positively the nervous character of the asthma in these cases is their paroxysmal appearance and the typical course which they often had. We saw the first case become strictly typical, as occurs in many cases of neuralgia. In all except the fifth there was found a typical duration of ten to twenty hours in the single attacks, and in others the attacks always appeared in the night. All these characteristics would not be found in case of dyspnoea caused by anatomical lesions, and can only be supposed in case of stoppage of the breath by spasmodic contraction of the bronchial tubes.

(To be continued.)

## Reports of Medical Societies.

BOSTON SOCIETY FOR MEDICAL IMPROVEMENT.  
CHARLES D. HOMANS, M.D., SECRETARY.

Nov. 28th.—*Tubercle of the Choroid in Acute Miliary Tuberculosis*.—Dr. O. F. WADSWORTH showed the specimen and a section through a tubercle under the microscope.

The occurrence of miliary tubercles in the choroid in this disease was first observed by Mauz. He published his first case in 1858 (*Archiv. für Ophthal.*), and five years later two others. In 1860, a fourth case was published by Busch, in *Virchow's Archiv*. With the exception of these isolated cases, nothing appeared on the subject till 1867, when Cohnheim (*Virchow's Archiv*, Band 39) published a series of seven successive cases, on which autopsies had been made at the Berlin Pathological Institute in the course of four months, in each of which either in one or both eyes the same characteristic deposit was found. Attention being thus excited to the probable diagnostic value of an ophthalmoscopic examination, Graefe and Leber were invited, in April, 1867, to examine a case in Griesinger's wards at the Charité Hospital in Berlin.

They found, with the ophthalmoscope, appearances according with those described by Cohnheim, and examination after death confirmed the diagnosis. This case was reported in detail, together with a case of Dr. Fraenkel, in the *Archiv für Ophthalmologie* for 1868. In January of the same year, J. Soelberg Wells reported a case in the *London Medical Times and Gazette*, and Dr. Fraenkel two more a year later. The specimen which I have here is from a case observed by Dr. Heymann, of Dresden, in 1868.

These six cases are, so far as I am aware, the only ones in which an ophthalmoscopic examination has been made. Of these, the three cases of Dr. Fraenkel are the most interesting, since in them the diagnosis was only made certain by means of the ophthalmoscope, in the first six days, in the second nine days, and in the third two months before death. The other three cases were correctly diagnosed before ophthalmoscopic examination. In five of the six cases the diagnosis was verified by autopsy. In the second case of Dr. Fraenkel no autopsy was allowed.

Meanwhile Cohnheim, in the ten months following his first published series of seven cases, had examined eleven others, and all with the same result, i. e., tubercles were found in the choroid in one or both eyes. In all these cases the miliary deposit was found in a large number of organs, and all, with one exception, were acute in their course. Cohnheim, moreover, examined the choroid in a large number of other cases, especially of localized tuberculosis of the lungs and intestine, and found it invariably free from tubercles.

With the microscope the tubercles are seen to consist of a rounded heap of lymphoid cells. They cause atrophy of the normal choroidal tissues locally, and after reaching a certain size undergo caseous degeneration, commencing at the centre. While still small they are situated in the inner layers of the choroid, close to the limiting membrane, and as they increase, give rise to a projection of this before extending to the posterior layers, but never cause its rupture. The larger ones may extend to the whole thickness of the choroid, and even cause a depression in the sclerotic. The pigment epithelium over the granules becomes gradually atrophied, commencing at the centre. The retina is simply pushed forward as the tubercles increase in size.

The ophthalmoscopic appearances are characteristic, and have been well described by Graefe. Greyish white patches, round,

or very nearly so, gradually shading off at the edges into the normal color of the fundus; the larger ones slightly elevated, and perhaps presenting a yellowish white opaque appearance at the centre or throughout, a result of caseous degeneration. This last characteristic was distinctly visible in one of Fraenkel's cases. Round, whitish patches may occur in some forms of choroiditis disseminata, but these usually only retain this shape while quite small, and soon acquire an irregular contour from the confluence of two or more neighboring deposits. In these, moreover, the whitish coloration never gradually shades off from the centre to the circumference, but either their surface presents an irregular increase and diminution of pigment, or there is an increase of pigment at the edges. The tubercles may occur in any part of the choroid, but in every case thus far examined, whenever only a few were present, they were situated in the posterior portion of the fundus, so that their discovery with the ophthalmoscope would have been comparatively easy.

In only one case was disturbance of vision complained of, and here there were numerous small hemorrhages in the retina. This was perhaps owing to accidental causes (the patient had given birth to a child a week before her death), perhaps to the large number of tubercles present, 52 in one eye and more than 40 in the other. No disease of the retinal vessels was found. In one other case, however, vision must have been impaired, since a nodule  $2\frac{1}{2}$  millimetres in diameter (the largest found in any case) was situated just behind the macula lutea; and it is quite possible that in some other cases the impairment was only masked by the general condition of the patients. Wells's case and the two last cases of Fraenkel were examined with reference to this point after the tubercles were seen and while the patients were in full possession of their senses, but no imperfection of vision was found.

I have brought this subject forward on account of the great diagnostic value which an ophthalmoscopic examination must have in suspected cases of acute miliary tuberculosis (tubercular meningitis), the difficulty of diagnosis in which is well known. The results of Cohnheim's investigations certainly show that in the vast majority of cases, at least, tubercles exist in the choroid, and may be observed during life.

Nov. 28th.—*Twin Labor; Two small Placentae, battledore, fused; Cords very short—one Ruptured at Birth.* DR. J. P. REYNOLDS reported the case.—X. L., primipara, æt.

28. Five years married—twins. First child a male, footling delayed in latter half of labor. Soon after the cord of this child had been tied, the placental portion of it was found torn off spontaneously. The second child, a female, several days dead, followed immediately, presenting by the head. There were two sacs; the united placenta hardly equalled in size an average single placenta; each cord was inserted at an outer edge—the cord of the living child had torn itself off at the point of origin from the placenta. This cord was fifteen inches long; that of the dead child only twelve. The mother should have been confined three weeks later; and the living child appeared to lack full development by about this number of weeks.

The mother, four weeks previously, had been for one day quite ill with severe cough. One week before labor she was thrown down with great force, striking on her side.

Fœtal movement had been throughout the pregnancy very indistinct.

By a remarkable coincidence the father of the children had a twin sister.

Nov. 28th.—DR. STORER reported the following cases:—

1.—*Placenta Prævia.*—I would refer to a case of placenta prævia which has occurred to me, within the past few weeks, to show how satisfactory, in some alarming cases, is the treatment proposed and practised by the late Prof. Simpson.

You are aware that in cases of placenta prævia, when the os uteri is so undilatable as to render it utterly impracticable to introduce the hand into the uterus for the purpose of turning, and the hemorrhage is urgent, Prof. Simpson has advised and practised passing the finger within the os as far as possible and separating the placenta—thus breaking up the connection between mother and child, and checking the hemorrhage at the loss of the life of the latter.

I was called, a few weeks since, to a lady in the eighth month of her pregnancy with her eighth child. I had attended her in seven of her confinements; she had always done well. Now, without any premonition, while sitting with her family, she was alarmed by a profuse hemorrhage from the vagina. She was immediately removed to her chamber, and I was sent for. Arriving at her house in a very short time, I found her in bed, literally blanched by the loss of blood, gasping for breath, and her pulse scarcely perceptible. Upon raising the bedclothes, the hemorrhage was found to be extreme. Introducing my finger into the vagina, the os was felt to have scarcely commenced dilatation; the extremity only

of the finger could be passed into it. I immediately sent for ergot, and felt I must act at once if my patient was to be saved; the tampon seemed out of the question, as the little additional blood which would inevitably be lost previous to its being checked by this method might destroy her. Accordingly, while stimulants were being administered, I endeavored to dilate the os; and by considerable continued effort was enabled to pass my finger into it, and to separate the placenta. Upon obtaining the ergot, half of a drachm of the powder was exhibited in infusion. Almost immediately after the placenta was delivered, the bleeding lessened, and soon entirely ceased, and with its cessation my patient began to rally and my fears to diminish. In the course of half an hour ergotine pains commenced and continued quite active for some time, when, having ceased, and the os being now sufficiently dilated, the forceps were applied and the child readily delivered. No untoward symptom supervened after delivery, and the lady was as well at the expiration of a fortnight as she had been at the same period in previous confinements.

I have not reported this case as a rare one, but to encourage any of my brethren who may find himself similarly situated.

II.—*Hæmorrhage from Rupture of the Hymen.*—In most cases the hymen is ruptured with but little pain and trifling hæmorrhage. Gaillard Thomas, in his essay on this organ, observes that the only case he had seen recorded of profuse bleeding at the time of sexual intercourse was that of Dévillier, whose surgical aid had to be employed to check it.

Several years since I reported to this Society a case which fell under my own observation.

In this case I was summoned before day-break to visit a lady at one of our hotels. I found her very pallid and exceedingly alarmed. She had been married a few hours before, and was now blanched by a profuse hæmorrhage from the vessels of a ruptured hymen. During the past week, I was called to a second case of this description. A vigorous sea-captain, who had been married four nights previously, was in great distress at the condition of his young wife, who had bled more or less profusely from the vagina each night since her marriage, and the bleeding continuing up to the evening of the fifth day, he could no longer delay asking for medical advice. The wife was exceedingly prostrated, not being able to move in her bed; her pulse was very feeble,

and she was constantly fainting—her bed-clothes saturated with blood.

From conversation with the husband, I was satisfied the lesion was produced by no slight disproportion of the genital organs.

I have related this case not merely on account of its infrequency, but of its importance in a medico-legal point of view—proving that serious if not fatal hæmorrhage may occur from this organ without any criminal intent having existed.

III.—*Incontinence of Urine.*—In the *Dublin Quar. Journal* for February last, Sir Dominic Corrigan proposed a new treatment for incontinence of urine—which consisted in the application of collodion—he considering “that the escape of the urine is owing to want of apposition in the sides of the canal of the urethra, or to a feeble state of the circular fibres which are supposed to constitute the sphincter of the neck of the bladder.” He recommends that “while the prepuce slightly curved up is held with the left hand, the little cup thus formed by the extremity of the prepuce be smeared over with collodion by means of a small camel’s hair pencil. Almost as fast as applied, the collodion solidifies. In contracting it draws closely together the edges of the prepuce, and thus the exit for the escaping urine is closed.” He also advises that the lower portion of the body should be gently raised to an inclined plane from hips to feet, so as to allow the urine in the bladder to gravitate towards its fundus.

Soon after reading his article, a case of incontinence falling under my care, and being often disappointed in the methods usually practised, I determined to pursue the above mentioned course.

The boy, aged  $7\frac{1}{2}$  years, had suffered since infancy from this infirmity. He had tried various remedies under the directions of different physicians, without any material benefit. At my suggestion the mother applied this collodion—and with immediate relief—not perfect at first, but in a few nights the entire night was passed without a drop of urine passing. At the end of three weeks the mother told me he had passed one or two nights without any discomfort, although the application had been omitted. In a short time the incontinence returned, and I learned the remedy had lost its effect. Upon inquiry I was told a second bottle of collodion was tried now, less adhesive. I advised the procuring some similar to that first employed. This was found very soon to answer the purpose. When last heard from, the boy was still exempt from

his trouble while he used this remedy, and frequently without it.

You perceive this is only a single case; and were it an original observation I might be ridiculed for reporting it, but as corroborating others already published, it may not be considered valueless.

Dec. 12th.—*Sir James Y. Simpson on the Treatment of Unavoidable Hæmorrhage by Extraction of the Placenta.*—Dr. Parks made the following remarks suggested by the case of *placenta prævia* reported by Dr. D. Humphreys Storer, at the last preceding meeting. Dr. Storer speaks of the artificial detachment of the placenta as “proposed and practised” by Prof. Simpson. Now the notion extensively obtains that the *proposal* of Prof. Simpson to detach the presenting placenta was *first started* by him. On turning to the 605th page of Simpson’s “Obstetric Memoirs—first series,” we find an elaborate paper with this caption: “The Complete Separation, and if necessary Extraction of the Placenta before the child.” The page referred to has at the top of it the words, “new practice proposed for *placenta prævia*.” The article begins with this paragraph, “I shall first state the grounds on which I venture to found the propriety of this proposed addition to the treatment of the very anxious and very dangerous cases of which we speak.”

We happen to know that a cursory survey of Prof. Simpson’s works has in point of fact sometimes led readers to suppose that there was no reference to any other writer as recommending the practice in question. But, on the 677th page of the volume we have alluded to, being the 72d page of the paper, which is 114 pages long, is the following statement in allusion to “a very interesting case” (previously mentioned in the memoir), of “expulsion of the placenta before the child, detailed by Mr. Chapman, surgeon at Amptill, Bedfordshire, and reported by him in the 4th volume of Dr. Duncan’s *Annals of Medicine*, published in the year 1800.” Prof. Simpson then proceeds to credit Mr. Chapman with “the first explicit suggestion as to the proper principle of treatment in some placental presentations,” and then quotes the words of Chapman as follows: “From the expulsion of the placenta to the birth of the child was full four hours. She (the mother) lost little or no blood. How far does this suggest a different practice to that in general followed? I mean that of delivering the placenta previous to delivering the child, in those cases of alarming

hæmorrhage where the placenta is situated on the side of, or over, the os uteri.”

Then, on the succeeding page (678), Prof. Simpson says that after the first part of his monograph was printed in the journal where it originally appeared, he became convinced that several years previous Mr. Kinder Wood, of Manchester, who died in 1830, advocated, under some circumstances of *placenta prævia*, “the total separation of the placenta in unavoidable hæmorrhage.” But the opinion is subjoined by Prof. S. that Mr. Wood divulged this practice only to “his immediate friends and pupils.” It should be noted that Wood recommended passing the *hand* through the os uteri in order to effect the detachment.

It is not strange, perhaps, that these passages should have been often or generally overlooked, since, while Prof. Simpson says he wrote the first part of his paper under the erroneous impression described, there is nothing more than the vague term “suggestion of Chapman” as one of several headings to the *section*, and nothing at all at the top of the page to attract notice to them.

There is no doubt that Prof. Simpson did a vast deal to call attention to this mode of practice; and that the separation of the placenta (partial or complete) in “unavoidable hæmorrhage” has met with a good share of success in the hands of others. That, however, it would have passed into oblivion, save for the efforts of Prof. Simpson, we are hardly warranted in assuming; since Radford, it is claimed, had previously adopted it, and advocated it on the basis of clinical experience; having perhaps been led to it through the possession of Kinder Wood’s MS. on the subject, which Radford afterwards published, among other writings of his predecessor.

It may not be amiss to mention here that the *rationale* of the production of the hæmorrhage in placental presentation, as set forth by Dr. Robert Barnes, in his recent work, is quite different from the theory of Levret, Rawlins, and Hamilton, which was adopted by Kinder Wood, Radford, and Simpson. Dr. Barnes further believes that the *entire* separation of the placenta *prævia* is not always necessary to the arrest of hæmorrhage; that it is not always feasible without the introduction of the entire hand; and that it has not always been accomplished by those who have (in good faith) alleged instances of its performance *digitally* by themselves.

SUFFOLK DISTRICT MEDICAL SOCIETY. REPORTED  
BY DR. F. W. DRAFER.

THE Society met Saturday evening, Nov. 26th, a large number of members being present, the President, Dr. Shattuck, in the chair.

Dr. John Homans presented two specimens of croupous inflammation of the larynx and trachea. Tracheotomy had been performed in both cases, and with marked temporary relief. Both cases survived thirty-six hours after the operation. In one case, a fragment of false membrane had appeared at the opening in the trachea at the time of the operation and had been withdrawn; in the other there was no such phenomenon.

The specimens presented well-defined appearances of a croupous membrane, lining the larynx and trachea; in one case degenerated to the purulent stage. Dr. Homans stated that no membrane was seen in the fauces during life except on one day only, a very small patch on one tonsil in one of the cases. He considered that death was due not to suffocation from extending deposits, but to asthenia from the depressing effects of the disease itself; essentially a blood-poisoning.

Dr. Jackson remarked that the term tracheitis, sometimes applied to membranous croup, was a misnomer, since, in his opinion, the inflammatory process involved both larynx and trachea almost invariably. The membrane adhered to the mucous lining of the larynx more closely than in the trachea, and this was liable to mislead.

Dr. Batchelder strongly recommended the use of steam in the treatment of croup.

Dr. Jackson recalled certain cases of croup reported by Dr. James Jackson a number of years ago, which were fatal, but in which no membrane was discovered post mortem.

Dr. Bowditch gave an interesting account of certain experiments in England in the use of earth-closets as a substitute for water service; and of plans which had been carried out on a large scale for the economizing of the contents of drains and sewers, by carrying it back from cities and towns, to be used as liquid manure on farms, instead of being discharged into harbors or rivers. He remarked, incidentally, that he had observed during his inspection of the large drains of London and other towns, that, while water stagnant was not a deodorizer, water in motion, as in sewers, had no perceptible odor.

Dr. Bowditch also exhibited an electric bul-

let probe. It was so constructed that on being passed into a bullet wound and coming on the lead, the concealed metal completed the circuit of the galvanic current and signalized the completion by an alarm bell. The same adaptation was made for bullet forceps, the two poles of the battery being connected with the two handles of the forceps.

Dr. Doe related the history of a case of Foreign Body in the Air Passages. The case was published in full in the JOURNAL for Dec. 29, 1870.

Dr. Cheever exhibited the pin, removed in the foregoing case, an ordinary shawl-pin about two inches long, and with a round bead at its head. He remarked that one of the noteworthy symptoms in the case was that when the child bent its head forward, pain was caused as if the point of the pin impinged at some part. He also observed that the polypus forceps which were used could be passed with unexpected ease into either bronchus, and he considered it the rule that the bronchi of children were relatively larger than those of adults. The wound in this case had been left freely open without sutures, yet air ceased to pass on the fourth day.

Dr. B. Joy Jeffries commented on cases of posterior synchia which had been relieved at the Eye Infirmary by Passavant's operation [see vol. vi. p. 166], both those which had been formerly reported by himself in this JOURNAL, and certain subsequent ones. In none of the nineteen cases under his observation had any recurrence of adhesion of the iris followed. In some instances he had used nitrous-oxide gas as an anesthetic, and in two or three cases no anesthetic was employed. Dr. Jeffries presented two patients to the society in which the operation had been successfully performed the day previous.

Dr. Amory, of Longwood, exhibited and described Fox's apparatus for the administration of nitrous oxide gas, the characteristic feature of it being the condensation of the gas, under a high pressure, in an iron cylinder, whose contents represented one hundred gallons of gas.

Dr. Amory inhaled the gas in the presence of the society, and demonstrated its anesthetic properties.

Dr. Both exhibited specimens of lung tissue under the microscope, designed to refute Kölliker's theory of the minute anatomy of the circulation in the lung, and to show that the capillaries lie free between the pulmonary vesicles, instead of in contact with them.

Dr. Bowditch described the "convalescent homes" which have been established in connection with some of the English hospitals, and hoped they would before long be organized here and thus fulfill a great need.

Dr. H. R. Storer hoped that latitude would be allowed in the matter of admission to such institutions, and that cases of women's diseases, excluded from most existing institutions, may there be admitted.

Dr. Doe explained the objects of St. Luke's Convalescent Hospital, recently established in this city.

Dr. Shattuck, while approving the project of convalescent homes, advocated strongly the establishment of hospitals for incurables.

Dr. Ayer also presented the need of a proper lying-in hospital in this city.

The Society adjourned.

## Medical and Surgical Journal.

BOSTON: THURSDAY, JANUARY 12, 1871.

### FIRST MEDICAL AND SURGICAL REPORT OF THE BOSTON CITY HOSPITAL.

THE volume\* which it is our privilege to notice is the first of its kind in Boston, and consists of a series of carefully written monographs on topics suggested by the practice of five years of a large and important hospital. We cannot fail to congratulate the profession that a work so valuable is placed before them, and to express our grateful appreciation of the Medical Staff which composed and the Board of Trustees which published the Report. Like the reports of the English hospitals, and those of New York and Philadelphia in our own country, the material of this volume is based on the most recent investigations of the day; like them it bears evidence of active, vigorous professional work; and in like manner it presents an important aggregation of results from extended data.

The report opens with a chapter on the history and a description of the hospital. We must omit any other mention of this portion of the work, and confine ourselves to the monographs which compose the prin-

cipal part. We note, however, with surprise and regret, that the name of a most able and faithful member of the medical staff has been omitted in the list of retired surgeons.

*Perinephritic Abscess, its Complications and its Treatment*, by Henry I. Bowditch. A history of ten cases of this disease is given, the continuation of an article on the subject communicated to this JOURNAL (Vol. I., No. 23, July 9, 1868), from which Dr. Bowditch draws inferences of importance in the etiology and treatment of the disease. He urges, in the first place, the liability which exists of latent or manifest chest complications in connection with and in consequence of the abscess below the diaphragm; these at times become the most important feature in the case, and one liable to produce long continued wasting disease, if not death.

Secondly, he endeavors to impress on the reader the importance of an early and thoroughly radical operation, whereby the pus may be allowed to escape; he believes that the delay which modern surgery would suggest till pointing or fluctuation at the part should be manifest, would in many instances be fatal in its effects. Still more important does he consider it to operate if thoracic symptoms be noticed, even if they be slight; and, *a fortiori*, if these signs be manifest and severe. In case there is little or no discharge of pus at the time of the operation, he would keep the wound open by setons or tents.

*On Excisions of Joints*, by David W. Cheever.—The larger joints were excised by the surgeons of the City Hospital 28 times in five years, in which experience the ratio of mortality was found to be 43 per cent. We must take the prominent points and conclusions in this article, as in all of the others composing the volume. Dr. Cheever has detailed nine cases of excision of the head of the femur. Five of these children are walking very well, one walks with crutches, and one is still in bed. It is still too soon to deduce positive experience as to the result of these cases; one thing, however, is evident, the operation is comparatively of slight importance, and the immediate relief to the patient is very

\* First Medical and Surgical Report of the Boston City Hospital. Edited by J. Nelson Borland, Physician; David W. Cheever, Surgeon, Boston: published by the Board of Trustees. 1870.

marked. He recommends it decidedly in children of the poorer classes. With those in better conditions of life, various considerations naturally influence the mind of the surgeon. "In the operation we undertake, on a larger scale, what nature constantly strives for, namely, to cast off and absorb the diseased bone. We expedite her processes. \* \* \* We get rid at once of the carious head of the femur, which is the centre of diseased action. We thus shorten the period of invalidism in poverty, and assure the child a better hope of recovery." Dr. Cheever regards the knee as affording the least prospect of success from excision of either of the large joints. Of the six cases operated on at the hospital, two subsequently came to amputation, one died, and three recovered with more or less useful limbs.

*Cases of Pneumonia*, by J. N. Borland. The tables given in connection with this article include 149 cases of pneumonia, and from these a series of valuable deductions is drawn. In speaking of the locality of the disease, Dr. Borland finds that, of 44 cases of double pneumonia, the two lungs were equally affected in 17; in 19 the right lung was most involved, in 8 the left lung. Of 59 cases of single pneumonia, the right lung suffered most in 40 instances; the left lung in 19. The highest temperature attained in the disease was usually 103° or 104°, but its height does not necessarily indicate the intensity of the disease. The temperature and pulse usually rise and fall together, and the temperature usually decreases before the frequency of the respirations diminishes. Of the cases reported, 10 died, or 1 in 10½ cases. Dr. Borland carefully reviews the death list, giving the immediate cause in each case. A series of valuable descriptive tables closes the article.

*Displacement of the Upper Jaw*, by David W. Cheever. The author here carefully describes the method of operating employed by himself for the treatment of nasopharyngeal polypi, giving the details of three operations done by him. The mode of operating is thus described by the author:—

"An incision was made from just below the inner canthus of the right eye, down-

wards by the side of the nose, following the naso-labial fissure, to the corner of the mouth. The inner flap was dissected up until the symphysis was exposed, and the outer until nearly the whole of the superior maxilla was free. With a narrow-bladed saw, about three inches long, the superior maxilla was now divided transversely, about half an inch below the floor of the orbit. The blade of the saw was plunged into the zygomatic fossa, and the front and back walls of the antrum were sawn through horizontally, starting just below the articulation with the malar bone and terminating in the anterior nares, at the lower end of the nasal bone. The ala of the nose having been lifted up, the right central incisor was next extracted. Strong bone forceps were now used to divide the alveolar process, through the socket of the right central incisor. The cut included the *alveolus only*. The hard and soft palate were not touched. The bone was now held by the palate process, palate bone and its coossification with the pterygoid processes. Seizing the alveolar processes with strong tooth forceps, the whole section of the superior maxilla was bent down and displaced into the mouth. \* \* \* The superior maxillary bone was now hanging with its antrum exposed, and attached by the bent or broken hard palate, the unbroken soft palate, and the broken osseous and unbroken muscular and vascular attachments of the pterygoid process of the sphenoid bone. On these attachments we were to rely for the restoration of the bone."

Dr. Cheever makes a comparison between the operations of Langenbeck and Ollier, and his own. The former, as will be remembered, attacks the foreign growth from the side, the second from the front through the upper meatus of the nose; and Dr. Cheever reaches it through the lower meatus. An interesting comparison thus presents itself: first, as to the relative room gained to operate in; second, as to the seat of the tumor; third, as to the arterial supply of the bony flap; and, lastly, as to the amount of external mutilation of the face.

Langenbeck's operation gives the most room, but also the greatest mutilation, and is more adapted to the class of tumors which he calls "retro-maxillary," which grow from the speno-maxillary fossa; Ollier's method presents a small amount of mutilation, but little room; in Dr. C.'s operation the minimum mutilation is obtained,

with a larger arterial supply than in either of the other processes, and also a sufficient amount of room for most naso-pharyngeal tumors.

*Treatment of Acute Rheumatism*, by John G. Blake. The object of the writer of this article was to ascertain, by a close comparison of results, whether certain remedies and modes of treatment confirmed claims made by their advocates, and to learn if any one possessed advantages over others in the cure of this most intractable disease. The alkaline treatment—that recommended by Dr. Fuller—consisted in the use of salts, generally of potash and soda, while the non-alkaline method included iodide of potassium, colchicum, opium and guaiacum. Indeed, all the recognized methods of treatment were employed by the gentlemen of the staff, and the results deduced therefrom are well shown by Dr. Blake.

Dr. Blake has carefully prepared a table of the cases of which he speaks.

*Treatment of Skin Diseases*, by H. F. Damon. The material of this report is drawn from a clinic of a thousand patients, and, of course, includes much that is interesting and valuable; it is, however, largely of a statistical character. The report is illustrated by three fine lithographs.

*Typhoid and Typhus Fever*, by J. B. Upham.—There are presented in this article, in condensed form, the history of all the undoubted cases of typhoid and typhus fever which have occurred in the hospital—152 of the former, and 38 of the latter disease. He gives a series of valuable deductions from the cases under notice, but we are obliged to pass hastily over them.

*Reproduction of the Tibia*, by David W. Cheever. A valuable review of three cases of reproduction of the tibia, after sub-periosteal resection, which occurred in the hospital.

*Ophthalmic Report*, by H. W. Williams. *Report of the Aural Department*, by J. Orne Green. The *résumé* of these two departments is mostly statistical, but none the less valuable.

*Two Cases*, by David W. Cheever. I. Encephaloid Tumor of Tonsil. II. Occlusion of Vagina, with a wood-cut from a sketch by Dr. George L. Underwood.

*Peri-Uterine Inflammation*, by A. D. Sinclair. This important subject in the study of the diseases of women has fallen into good hands, for the author has given a faithful clinical record. The article comprehends, under the title *Peri-Uterine Inflammation*, those pelvic affections described for many years under various names, chief among which are *Intra-Pelvic Phlegmonous Abscess*, *Pelvic Cellulitis*, *Pelvic Peritonitis*, and *Peri-Uterine Inflammation*. It is, indeed, what its author claims for it, a faithful clinical report of twenty-three cases presenting details of interest to the practitioner.

*Surgical Abstract*, by David W. Cheever. Aneurism; ligature of vessels; cases of cut throat; tracheotomy; foreign bodies in the œsophagus; perineal section; lithotomy; radical cure of hernia; strangulated hernia; fractures; fractures of spine; compound fractures; amputations. We can give this portion of the report a review only by title, and yet it is equally worthy of notice with any portion of the volume. It is, in fact, a practical *résumé* of the hospital in the general surgical branches named, giving in each the experience of the surgeons of the staff in the most recent operations.

A set of medical and surgical tables, giving classification and result of diseases, &c., closes the volume.

After carefully looking over this imposing volume, and reviewing its various articles, we cannot fail to express our gratification at its perusal. It is a compendious review of the treatment of nearly 24,000 patients, with every advantage which modern medicine and surgery can supply. We have barely touched on the contents of the book; but must leave its careful perusal to the leisure hours of our readers.

Part of the clerical work of the report has been done—and well done—by Drs. Doe, Draper, Folsom, Brigham, and others.

We feel called upon to note the beautiful typographical execution of the work at the hands of the City Printers. It is much to be regretted, however, that the very heavy paper employed has made the volume quite unwieldy.

EPISTAXIS. *Messrs. Editors*.—A few years ago, a non-medical neighbor told me that he could always arrest bleeding at the nose by

firm compression with the thumb and forefinger, holding the head forward and breathing by the mouth. I have since tried this plan in many cases, with prompt success. Recently, I have noticed that Prof. Gross, in his "Surgery," recommends the same. This is a more "simple method" than the "writer in the *Gazette des Hôpitaux*" suggests, as related in the last JOURNAL, and more effectual; for to arrest the blood in one branch of the facial artery might not be sufficient, as a supply would be afforded from the opposite side. The method I propose arrests the blood in the branch on each side, and in the artery of the septum also.

J. O. WHITNEY, M.D.

Pawtucket, R. I., Jan. 7, 1871.

DR. DUNSTER ON THE RELATION OF SCIENCE TO RELIGION.—Science has furnished that great argument of natural religion which deduces a First Cause from the evidences of design, with its most striking and convincing illustrations. "Science," says Prof. Youmans, "is the revelation to reason of the policy by which God administers the affairs of the world." And every discovery which science has made only furnishes additional proof of the constant and overpowering control of a Supreme Being. Rightly interpreted, then, science, so far from fostering scepticism, is the most powerful agent in dispelling it—the strongest support which true religion can bring to its aid.

ANNUAL MEETING OF THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA.—The Medical Society of the District of Columbia held its fifty-third annual meeting on January 3d, Dr. W. P. Johnson presiding.

The annual election was held, and resulted as follows:—President, Dr. J. M. Toner; Vice Presidents, Drs. S. C. Busey and Wm. Marbury; Corresponding Secretary, Dr. W. B. Drinkard; Recording Secretary, Dr. W. W. Johnston; Treasurer, Dr. F. A. Ashford; Librarian, A. F. A. King; Board of Examiners, Drs. W. G. Palmer, D. R. Hagner, Lewis Mackall, Jr., B. Thompson, C. M. Ford; Censors, C. H. Liebermann, J. F. Thompson, and Thomas Miller.

Dr. Toner, upon taking the chair, thanked the society for the honor done him in electing him to preside over the deliberations of this, the oldest and largest medical organization in the District. In the course of his remarks he gave the following

*Interesting Medical Statistics.*—The Medical Society has upon its rolls as members the number of 291; deceased or removed

from the District, 131; members in active practice, 150; members retired from practice, 12; licentiates engaged in practice, 18; members attending hospitals in the District, 15; members engaged in teaching in medical colleges, 20; members who hold salaried offices and clerkships, 20.

About sixty physicians (not licentiates) claiming to be regularly educated, many of them holding Government clerkships, about one half of whom are graduates of our own colleges, are at the same time engaging in practice. Many of them will eventually become members of this society. The proportion of physicians to population generally is one in from five hundred to a thousand. Two hundred and four physicians in the District have paid the special tax of \$10 to the General Government for the past year; which, of course, includes all varieties of practice. About fifty persons, who do not pay any license, present themselves before the public as physicians.

*The Annual Address and Supper.*—The annual address and supper of the Medical Society of the District of Columbia took place on Wednesday evening, the President, Dr. Toner, in the chair. The address was delivered by Dr. S. C. Busey, after which the society partook of its annual supper.

TARTAR EMETIC—AN ANTHELMINTIC. By J. DABNEY PALMER, M.D., Monticello, Fla.—My attention was directed to this property of tartar emetic by observing the discharge of worms in several cases in which the medicine had been employed for other indications. It is calculated to expel the round worm as effectually as the tape.

A little girl of five years was threatened with inflammation of the brain, for which two or three doses of the antimonial were administered. After taking the last dose she passed a large round worm, and, as no anthelmintics had been given, the result was ascribed to the antimonial.

Mrs. M. gave her child hive syrup, and, in order to induce the child to take it, she took some herself, which was followed by the discharge of eighteen inches of tape worm.

These worms were passed alive, owing, in all probability, to the minute quantity of tartar emetic taken.—*American Journal of Pharmacy.*

ABSORPTION OF MERCURY THROUGH SKIN AND MUCOUS MEMBRANES.—Dr. Rindfleisch, of Bonn, has been making some experiments on rabbits with mercurial ointment,

which are worth relating. In order to prevent the animals licking the parts, the ointment was rubbed into the inner aspect of the ears. After rubbing the ear of a rabbit for some time with blue ointment, and washing the part with soap and water, the ear was snipped off, and laid under the microscope. After making these preparations, Dr. Rindfleisch became convinced that not one particle of quicksilver passed through the epidermis. The malpighian net was quite free from any particle. He then put some blue ointment into a rabbit's eye, closing up the eyelids by sutures. The result again was negative; no particle of mercury passed through the conjunctiva. Convinced that the result would be different in the bowels, he fed rabbits with potatoes in which blue ointment was mixed. They died pretty quickly. The mucous membranes of the bowels were found hyperæmic, and some small ulcers covered the membrane in many parts. There were quicksilver particles found in the intestinal glands, absorbed by the open mouths of the absorbents from the ulcers. The blood did not contain a single particle; nor did the liver, spleen, lungs, brain, kidneys or bones. Next, small pieces of blue ointment were placed in the peritoneal cavity of rabbits, and the result was again negative. There were particles found in the lymphatic of the diaphragm; but only there. Dr. Rindfleisch, therefore, concludes—1. That quicksilver contained in mercurial ointment passes neither through the outer skin, nor the mucous membrane, nor the serous membrane, so long as these are inviolate; 2. That it, on the other hand, passes along the open parenchymata of the body, through open lymphatic vessels and the base of phagedænic ulcers.—*London Med. Press and Circular*.

**A BURNING EARTH.**—A curious industrial application of a hydro-carbon called ozokerit, found as a mineral product in Moldavia and Wallachia, has been made in England. A firm, noticing its brilliant light when burned, decided to experiment on it with the object of making candles. To all appearances this was a most unpromising idea. The ozokerit, in its natural state, is a dirty, brownish-black mass, and the public have been so luxuriously educated in the matter of illumination that nothing but a very handsome candle can compete with the lights of the present day. The success of the enterprise has, however, been perfect. By sundry processes of distillation and purification, a beautiful, white, hard,

waxy substance is produced, handsomer than spermaceti, not so transparent as paraffine, but possessing a brilliant gloss, and melting at a temperature of 140° Fahr. This high melting point (paraffine being about 125° and stearine 130°) allows the employment of a larger wick, and this, combined with the naturally brilliant light of the ozokerit itself, makes the candles burn with a brightness exceeding that of any now in use.—*Med. and Surg. Reporter*.

**BLOOD-PICTURES.**—Dr. Day, of Geelong, Australia, the improver of the guaiacum-tests for blood and other animal fluids, confirms the discovery of Neumann, that the picture or net-work formed by human blood can be distinguished under the microscope from that which is formed by the blood of other animals. He says he has repeated the experiment, which is "wonderfully simple," almost every day for the last two months, with invariable success. A small drop, not a mere speck, of the blood is to be placed on a microscope-slide, and carefully watched, at a temperature of 10° or 12° Reaumur (=54.2° to 59° Fahr.), until the picture or net-work formed by its coagulation is developed. Human blood speedily breaks up into a "small-pattern" net-work; the blood of other animals (calves, pigs, &c.) takes a longer time, and makes a large pattern; but the blood of every animal seems to form a characteristic "picture." Dr. Day has examined the blood of calves, pigs, sheep, rabbits, ducks, hens, several kinds of fishes, &c., as well as that of man, and has found the results to be trustworthy and constant.—*New York Med. Journal*.

**TREATMENT OF IRITIS.**—The therapeutic indications are: 1st. Removal of the causes that are still somewhat active. 2d. Keeping away all sources of injury which may maintain or even increase the inflammatory process. 3d. Diminution and limitation of the proliferation of tissue, and a reduction to the normal mean of the increased nutrition. 4th. Prevention of the possible dangers from iritic neoplastic formations. 5th. In case this latter does not succeed, the direct removal or lessening of the disturbance of function caused by them.—*Stellweg on the Eye*.

Dr. BESNIER prescribes compresses soaked in a concentrated infusion of leaves of digitalis, kept applied to the scrotum, in orchitis and hydrocele.

## Medical Miscellany.

**CORRECTION.**—In the JOURNAL of December 29, 1870, we failed to credit the extract on Analgesia in Vertebral Caries compared with that in Hysteria, to *The Journal of Psychological Medicine*, for which it was translated from the *Vierteljahrsschrift f. d. prakt. Heilkunde*.

**APPOINTMENT.**—Dr. Oscar C. DeWolf, of Northampton, has recently received the appointment of Prof. of Surgical Anatomy in the Cleveland Medical College.

**SINGULAR MALFORMATION.**—The following malformation, in a girl of 20 years of age, is described by Dr. Constantinides, in *The Canada Lancet*: She hardly presented any traces of the external genitals. No labia were to be seen, no nymphæ, no vagina, no clitoris, no mons, in short no appearance whatever even of the very rudiments of the external organs of generation. A slight crease about one inch in length and a few lines deep, covered with a roughened sort of mucous membrane having much the character of the adjoining epidermis over the perineum, occupied the place of the vulva. In the centre of this, a small opening indicated the orifice of the urethra, through which a female catheter, which I introduced, passed directly into the bladder.

Although it was more than three years since I had seen her last, and she was now past her twenty-first year, her sexual system was wholly undeveloped, and she looked and acted in all respects like a child.

On her death, I entreated her friends to allow a post mortem, and to let me have an autopsy of, at least, the contents of her pelvis, but the same morbid delicacy which, against all my urgent and incessant requests, prompted them to refuse any other medical man to be a witness of her deformity during her life, led them also to kindly yet decidedly refuse my request at the end.—*Med. and Surgical Reporter*.

**CASE OF VARIOLA TEN DAYS AFTER SUCCESSFUL VACCINATION.**—An infant, 27 days old, having every appearance of health, was brought to the Hospice des Enfants-Assistés on February 28, and vaccinated next day. On March 8, on account of the perfection of the pustules and the vigor of the child, twenty nuns, fifteen nurses, and a ladies' boarding-school were all revaccinated from it. The next day an eruption appeared, which proved to be variola, of which the child died on March 13. None of those vaccinated from it took smallpox. In several the revaccination succeeded.—*Revue Méd.*, Sept. 3.

**BELLADONNA IN ASTHMA.**—The action of belladonna in asthma is twofold. It acts upon the vessels of the spinal cord, and diminishes its sensibility. Secondly, it acts upon the large pulmonary vessels, causing them to contract, and so stimulating the pulmonary circulation. Belladonna seems to cause contraction of the muscular fibres of all the large arteries, it also produces more rapid action of the heart.—*Medical Archives*.

To detect the presence of strychnia, it is suggested by a Prussian chemist, to saturate the suspected substance with ammonia, and allow it to dry spontaneously, then heat it with a little amylac alcohol, after which a few drops of the liquid is to be added to sulphuric acid and bichromate of potash, when, if strychnia be present in substance, the well-known coloration characters of alkaloid will be obtained.—*National Med. Journal*.

**TO CORRESPONDENTS.**—Communications accepted:—A Case of Gastric Ulcer.

**PAMPHLETS RECEIVED.**—Circular No. 3, Surgeon-General's Office, Washington, D. C. Approved Plans and Specifications for Post Hospitals. 4to. Plates I to V.—Do. No. 4. A Report on Barracks and Hospitals, with Descriptions of Military Posts. 4to. Pp. 494.—Transactions of the Twentieth Anniversary Meeting of the Illinois State Medical Society, held in Dixon, May 17-18, 1870. Pp. 141.—Proceedings of the Convention for the Reorganization of the Medical Society of the State of California, held in San Francisco, Cal., Oct. 19 and 20, 1870. Pp. 41.

**MARRIED.**—At Charlestown, 4th inst., Stephen Cushing, M.D., of Boston, to Miss Annie E. Little, of C.—At Lynn, 7th inst., J. H. Foster, M.D., of Chicago, to Mrs. Elizabeth A. Jewett, of Lynn.

**DIED.**—At Needham, 7th inst., Dr. Josiah Noyes, 72 years.—At Charleston, S. C., 3d inst., John T. Cole, M.D., of Newburyport, a member of the class of 1860, Harvard College, 29 yrs. 10 mos.

### Deaths in sixteen Cities and Towns of Massachusetts for the week ending Jan. 7, 1871.

Cities and Towns.	No. of Deaths.	Prevalent Diseases.
Boston . . . . .	111	Consumption . . . . . 61
Charlestown . . . . .	14	Pneumonia . . . . . 30
Worcester . . . . .	22	Croup and Diphtheria . 10
Lowell . . . . .	14	Typhoid fever . . . . . 8
Milford . . . . .	4	Scarlet fever . . . . . 7
Chelsea . . . . .	3	Whooping cough . . . 3
Cambridge . . . . .	19	
Salem . . . . .	8	
Lawrence . . . . .	4	
Springfield . . . . .	5	
Lynn . . . . .	14	
Fitchburg . . . . .	4	
Newburyport . . . . .	6	
Somerville . . . . .	5	
Fall River . . . . .	9	
Haverhill . . . . .	3	
	245	

GEORGE DERRY, M.D.,  
Secretary of State Board of Health.

**DEATHS IN BOSTON** for the week ending Saturday, Jan. 7th, 111. Males, 57; females, 54. Accident, 1; apoplexy, 1—disease of the bowels, 1—inflammation of the bowels, 1—bronchitis, 1—inflammation of the brain, 1—congestion of the brain, 2—disease of the brain, 2—cancer, 2—consumption, 32—convulsions, 2—debility, 2—diarrhea, 1—dropsy, 1—dropsy of brain, 2—erysipelas, 1—eczema, 1—erysipelas, 1—scarlet fever, 4—typhoid fever, 4—gastritis, 1—disease of heart, 3—hemorrhage of bowels, 1—disease of the kidneys, 3—disease of the liver, 1—inflammation of the lungs, 15—congestion of the lungs, 1—marasmus, 3—measles, 1—old age, 3—paralysis, 3—premature birth, 2—puerperal diseases, 2—rheumatism, 1—smallpox, 1—disease of throat, 1—teething, 1—syphilis, 1—unknown, 5.

Under 6 years of age, 31—between 5 and 20 years, 9—between 20 and 40 years, 34—between 40 and 60 years, 17—above 60 years, 20. Born in the United States, 69—Ireland, 29—other places, 13.